

PROGRESS OF MEDICAL SCIENCE

MEDICINE

UNDER THE CHARGE OF

W. S. THAYER, M.D.,

PROFESSOR OF CLINICAL MEDICINE, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MARYLAND,

AND

ROGER S. MORRIS, M.D.,

CHIEF OF THE DEPARTMENT OF INTERNAL MEDICINE, CLIFTON SPRINGS SANATORIUM AND
HOSPITAL, CLIFTON SPRINGS, NEW YORK.

Cultural Results in Hodgkin's Disease.—BUNTING and YATES (*Arch. Int. Med.*, 1913, xii, 236) have secured a pure culture of a pleomorphic diphtheroid organism in 3 cases of Hodgkin's disease. In two other cultural attempts the organism was recognized, but was not secured in pure culture, and in a sixth case a similar organism, morphologically, was stained in the lesions of a primary intestinal Hodgkin's case. The organisms grow luxuriantly on glycerin-phosphate-agar under both anaërobic and aërobic conditions. Long, granular, banded, and club-shaped involution forms appear on dry medium. On moist serum the organisms are short and plump, with polar staining. Many of these forms are coccoid. The organism stains by the Gram method. It is not acid-fast. Bunting and Yates feel they are dealing with the same organism described by Negri and Mieremet, and the latter's results, combined with the authors', indicate strongly they are dealing with the cause of Hodgkin's disease. The morphological elements obtained by Fränkel and Muck, by the antiformin method, in 12 out of 13 cases are so similar as to be added support. Animal experimentation is in progress. The name suggested for the organism is *Corynebacterium Hodgkini*. The frequent finding of a white staphylococcus, plus the polymorphonuclear leukocytosis, occurring late in the disease, suggest that possibly a secondary infection plays a part in the development of the disease.

Inequality of the Radial Pulses in Chronic Syphilitic Aortitis.—LAIGNEL-LAVASTINE and VINHIT (*La Presse Med.*, 1913, p. 607) have observed unequal radial pulses in three patients in whom radioscopy determined the absence of an aneurysm. In all, the left was smaller

and delayed as compared to the right. All the patients had syphilis. Two had aortic insufficiency. In each the aorta was elongated, a little dilated and tortuous, but no trace of an aneurysm was demonstrable. This was confirmed at autopsy in one case. It is striking that the inequality was much less marked in one case after mercurial treatment.

Pulsus Alternans in Myocardial and Arterial Disease.—With a view to ascertaining the value of pulsus alternans as a sign of disease of the heart, its frequency in different conditions, and its prognostic significance, WINDLE (*Quart. Jour. Med.*, 1913, vi, 453) has analyzed 33 cases coming under his observation. In order of frequency it occurred in the following conditions: (1) Arterial and myocardial disease; (2) chronic heart disease due to rheumatism; (3) pneumonia; (4) paroxysmal tachycardia; (5) acute rheumatic carditis. Ten cases were still under observation, but in more or less serious condition. Fourteen cases were fatal. Pulsus alternans was present in each patient when coming under observation. One case lived nearly two years. The rest died within a year. Nine other fatal cases developed pulsus alternans while under observation. The time of inception was known within a year; 2 lived eighteen months, and 2 twenty-four months. This supports Mackenzie's experience that the inception of pulsus alternans in aged people has invariably been followed by fatal heart failure within two or three years. In the 9 cases, last mentioned, there was no evidence of disease on clinical examination, except the pulsus alternans, to warrant a grave view being taken of the prognosis. When once present, pulsus alternans will never again be absent for long, because the exhaustion of the heart which it expresses is due to degeneration of the heart muscle. In the early stages alternation becomes latent for a time through bodily rest, or the action of drugs which slow the heart, but it eventually persists with rest and in spite of any measures of treatment yet tried.

Diagnosis of Typhoid Fever on Admission to a Hospital.—SHATTUCK and LAWRENCE (*Boston Med. and Surg. Jour.*, 1913, clxix, 228) believe typhoid fever should be suspected in patients entering a hospital after suffering from febrile conditions of a few days' duration. They should be treated under precautions to prevent the possible spread of infection. In a series of 100 non-typhoid patients of fourteen years of age or older, in which typhoid fever was suspected, bronchitis, bronchopneumonia, and influenza represent 29 per cent., or nearly one-third of the whole, undiagnosed fevers 15 per cent., gastro-enteritis, diarrhea and colitis, 12 per cent. They emphasize the importance of the differential diagnosis. The absence of rose spots at first examination has the same little weight for diagnosis as splenic enlargement not demonstrable by palpation and a negative Widal test. The absence of leukocytosis in a febrile disease strongly suggests typhoid fever. A count below 5000 is unusual in conditions simulating typhoid. A white count above 9000 is presumptive evidence against typhoid. Ordinary bronchitis, as a rule, entered the hospital during the first week, and typhoid with signs of bronchitis generally during the second week of illness. Congestion of the bases of the lungs, when present